Submission
No 221

INQUIRY INTO DENTAL SERVICES IN NSW

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Theme:

Summary

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June 20, 2005

Chair,
Inquiry into Dental Services
The Standing Committee on Social Issues
Legislative Council
Parliament House
Macquarie Street
SYDNEY NSW 2000

Dear Sir/Madam,

A Submission to the Inquiry into Dental Services in NSW from the Oral Medicine Society of Australia and New Zealand (OMSANZ)

Thank you for the opportunity to address to your Committee our Society's concerns as to the state of oral/dental services in the state of NSW.

Some background into our Society and the specialty of Oral Medicine may be of interest. Oral Medicine is a relatively new, specialist discipline of Dentistry that stands at the "interface" with medicine. Oral Medicine specialist practice entails the diagnosis and assessment of diseases of the teeth and oral cavity and adjacent structures, with a focus on mucosal pathology. Management is principally by non-surgical that is by pharmacological therapies. A specialist in oral medicine is akin to that of a "dermatologist of the mouth", alternatively they are possibly better termed "oral physicians" (a large aspect of specialist training is in various aspects of internal medicine). Clinical practice ranges from the management of oral ulceration, oral cancer and pre-cancer, oro-facial pain, and xerostomia. The provision of dental assessment and care to medically-complex patients, such as organ and bone marrow transplant recipients, post head and neck radiotherapy patients, and patients with severe immune compromise, in both the in-patient (hospital) and out-patient setting is also a substantive aspect of specialist oral medicine practice.

The Society has a number of concerns in regards to the state of oral medicine practice in NSW. In summary, these are:

- The insufficient number of oral medicine specialists in NSW.
- Inadequate and costly access to key pharmacological agents for the treatment of oral disease, but limited by lack of access to key PBS-listed drugs.
- Lack of Medicare Item number for the provision of essential "medically-necessary" dental care.

The Insufficient Number of Oral Medicine Specialists in NSW

In the whole of NSW, at this time, there are only two (2) full-time specialists in oral medicine, and one junior registrar, not due to complete her training until 2007. Workforce requirements would suggest that one FTE (full-time equivalent) oral medicine specialist is required per million head of population. That would entail at leat 6 FTE specialists in oral medicine are needed in NSW. The current two specialists are both, essentially based at Westmead Hospital. There is no out-reach services or clinics to any regional or rural centre in NSW. There are very limited services at Liverpool and Sydney Dental Hospitals. There is the equivalent of 0.2 FTE private oral medicine service presently available, through the facilities of the Skin and Cancer Foundation Australia (SCFA) in Darlinghurst and Westmead. This number of oral medicine specialists in NSW needs to be compared with the numbers interstate: 9 specialists in private and public practice in Victoria, 3 in Queensland, 1 in South Australia, and 3 in Western Australia.

These two specialists are responsible for all the clinical services, plus undergraduate teaching, post-graduate training of registrars, and continuing professional education, as well as research and publications in oral medicine for all of NSW. By any measure, this situation is unsustainable.

The lack of oral medicine specialists is easily attributed to a number of key factors, problems that are common, and directly results in the dearth of specialists in other disciplines in dentistry:

- Under-resourced public oral health sector to support specialist training.
- The cost of specialist training: $20 000 p.a, for each of the three years of the training programme (total $60 000). This cost (in fees payable to the University) is not covered by the half (0.5 FTE) dental officer salary provided to trainees of only ~$25 000 p.a..
- The unattractive salary and conditions provided to dental specialists in the public hospitals. Dental specialists undertake the same rigorous, lengthy training as their medical colleagues, and accept clinical, legal and administrative responsibilities comparable to that of their specialist medical colleagues (Consultant Medical Officers) but for only two-thirds the salary and conditions enjoyed by their medical counterparts.

The Society would like to see proper remuneration, and fully funded training schemes to address the shortage of oral medicine specialists. Further, they would ask that oral medicine specialists are given parity or even better, are covered by the salaried specialist medical officers' award (as their oral surgical colleagues are). This would provide them with pay and conditions, being consistent with that of their medical colleagues, that would be attractive to recruiting and retaining oral medicine specialists,

Restricted Access to Key PBS Listed Drugs Essential for Oral Medicine Practice.

The PBS (Pharmaceutical Benefits Scheme) has been both highly successful and fundamental in substantively harbouring patients from the true cost of their much-needed medications by providing heavy subsidies at the point of sale. Historically, holders of dental qualifications have a much more limited number of PBS-listed (that is PBS-supported) drugs that they could prescribe for their patients. In essence, select antibiotics, analgesics, and (local) anaesthetic agents. It is not illegal for holders of dental qualifications to prescribe items not on the PBS's "Dental List" (that is all drugs categorized S4 or lower). However, items prescribed by dentists, not on the PBS's Dental List meant that the often substantive, un-subsidised, full-price had to paid by the patient. There are a number of key classes of drugs essential for treatment of oral mucosal and associated diseases, namely corticosteroids (topical and systemic), anti-depressants and anti-epileptics, for the management of atypical neuropathic oro-facial pain, and select antibiotics (anti-fungals and anti-virals). Oral medicine specialists spend a considerable portion of training in clinical pharmacology, becoming experienced in the safe prescribing of such agents. But, because of a historical precedent, intense financial constraints imposed on the PBS, and not because of any risk to patients, oral medicine specialists are essentially barred from prescribing the appropriate medications to treat their patients properly. Asking patient's medical practitioners to prescribe such items is cumbersome, medico-legally questionable, and hazardous to patients. This essentially administrative problem acts as further cost barrier to providing public oral medicine services, and has substantively stymied the provision of private oral medicine services to those able and willing to pay for such services (so relieving the burden on the limited public services).

The Society would call upon the State Government of NSW through the offices of NSW Health to have this issue addressed by their Federal counterparts so that the appropriate drugs are available at a reasonable cost i.e PBS-Listed (PBS-subsidised) to sufferers of various oral diseases.

Lack of Medicare Item Numbers for the Provision of Essential "Medically-Necessary" Dental Care

There are a very limited number of systemic medical conditions or diseases, and interventions in which the provision of dental/oral medical care is considered vital, if not, probably life-saving for the patient:

- Prior to cardiac (heart) valve replacement surgery: infected teeth, gum disease and poor oral hygiene leads to bacteraemias (oral bacteria finding their way into the bloodstream) that can attach, infect, and even destroy the replacement heart valve's attachments, often killing the patient.

- Prior and post organ or bone marrow transplantation: organ (heart, lung, liver, and kidney) and allogenic bone marrow (often for leukaemia) transplant recipients will need to be on life-long immuno-suppressant therapies to prevent "rejection" by the patient's immune system and loss of the transplanted organ (or bone marrow). This renders such patients also at life-long risk from infections. One common source of under-recognised and untreated infections is from teeth, gums and oral mucosal disease (often fungal infections).

- Prior and post radiation therapy for cancers of the head and neck: Radiotherapy cures a number of different cancers of the head and neck. However, radiotherapy causes a number of life-long serious problems: permanent dryness of the mouth ("xerostomia") resulting in rapid and rampant form of dental decay ("radiation caries"); and increased risk of aggressive, highly difficult to treat, infection of the jaws (an "osteomyelitis" (= bone infection)) termed "osteo-radionecrosis" that causes severe morbidity, and albeit rarely, death. Dental assessment and removal of broken down, infected or diseased teeth is therefore considered to be essential prior to radiotherapy to the head and neck

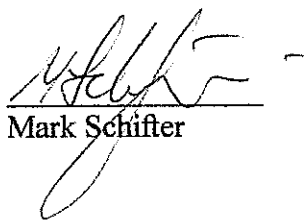
- Consultation and biopsy for potentially malignant lesions and early cancers of the mouth: oral cancer is highly preventable, particularly with opportunistic screening of "smokers and drinkers" and biopsy (removal of small piece of tissue for examination under the microscope) of suspected oral pre-cancers and early cancers. The mortality rate for oral cancer is still 50% at five years (from the date of diagnosis). The morbidity for patients (see above) and the cost to the community (see above) of the surgery and radiotherapy for oral cancer is high, but potential preventable with earlier diagnosis and so intervention.

For these select conditions listed above dental assessment, dental care and treatment ***prior***, and for some limited conditions after, is life and cost-saving. For these conditions, such dental care is a medical necessity, and is of proven cost-benefit to the community that subsidises the care of such patients through our Medicare system. Of interest there are already Medicare Item Numbers for sufferers of cleft lip and cleft palate for the orthodontic and prosthodontic (that is ostensibly the dental care) such patients require for their full and proper rehabilitation. Similarly, a limited number of Medical Item Numbers, with appropriate subsidies should be available for the dental/oral medical care and treatment of patients needing heart-valve replacement, organ and bone-marrow transplant recipients, patients needing radiotherapy to the head and neck and those patients with suspected oral cancer. This would help to defray the costs, and serve as an incentive to provide more of such dental/oral medical services to patients, who are misfortunate enough to suffer from these select conditions. The numbers and therefore the costs would be relatively small. The present "Extended Primary Care Plans" offered by the Federal Government at the last election for "auxiliary" services such as dental, are hopelessly bureaucratic, target the wrong group of patients, and operated by general medical practitioners removed from the major teaching hospitals where such patients are actually being treated.

The Society would again call upon the State Government of NSW through the offices of NSW Health to have this issue addressed by their Federal counterparts. It is time for a number of "Medically-Necessary Dental/Oral Medical Care" Medicare Item Numbers are established (as has occurred in the United States in 2004) to enure timely appropriate dental/oral medical care and treatment is provided to patients with these select medical conditions (or interventions), as listed above.

In closing, I would like to thank the Chair, and Committee members, in anticipation for accepting this submission, on behalf of the Oral Medicine Society of Australia and New Zealand (OMSANZ). I am available at the Committee's convenience to answer, in person, any questions, queries or concerns raised by this submission.

Yours truly,



Mark Schifter